passed, the motion to reconsider by laid upon the table, and any statements regarding this matter appear in the RECORD at this point.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The bill (S. 2231) was read the third time and passed, as follows:

S. 2231

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Welfare Reform Extension Act of 2004''.

SEC. 2. EXTENSION OF THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT PROGRAM THROUGH JUNE 30, 2004.

(a) IN GENERAL.—Activities authorized by part A of title IV of the Social Security Act, and by sections 510, 1108(b), and 1925 of such Act, shall continue through June 30, 2004, in the manner authorized for fiscal year 2002, notwithstanding section 1902(e)(1)(A) of such Act, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the third quarter of fiscal year 2004 at the level provided for such activities through the third quarter of fiscal year 2002.

(b) CONFORMING AMENDMENT.—Section 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C. 603(a)(3)(H)(ii)) is amended by striking ''March 31'' and inserting ''June 30''.

SEC. 3. EXTENSION OF THE NATIONAL RANDOM SAMPLE STUDY OF CHILD WELFARE AND CHILD WELFARE WAIVER AUTHORITY THROUGH JUNE 30, 2004.

Activities authorized by sections 429A and 1130(a) of the Social Security Act shall continue through June 30, 2004, in the manner authorized for fiscal year 2002, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the third quarter of fiscal year 2004 at the level provided for such activities through the third quarter of fiscal year 2002.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

THE MARINES

Mr. THOMAS. Mr. President, I will make some comments in morning business. First of all, I had the privilege this morning of attending a meeting of Marines, which we have periodically, and I was very pleased to listen to a report from the commandant about the current situation in Iraq and Afghanistan. Certainly, he is very pleased with what is happening there with regard to our military, what they are able to do and accomplish there. We do not hear much about the good stuff that is going on. We hear, of course, the news on bad things. It was an excellent report. Certainly we are very proud of our Marines and all of our service personnel there.

HEALTH INSURANCE COSTS

Mr. THOMAS. Mr. President, I take a few minutes today to talk about an issue I am sure we are all concerned about and interested in. As I go about Wyoming and talk to people, particularly in town meetings, the issue that arises most often and with the most passion is the high cost of health insurance. The cost of health insurance is directly related to the cost of health care. What we hear the most about is from people who are in private business, farmers and ranchers, who provide all of their own health care costs, which have become increasingly prohibitive. It seems to me we are going to have to focus properly on Medicare, Medicaid, veterans, those government programs for which we are responsible. I suggest we need to focus now and begin to take a look at the broader picture of health care. We have a system that has available certainly some of the best health care in the world, but the key is to have access. If the cost limits access, we have a problem.

We have some unique features in Wyoming. Because of a small population, we cannot have all the various professional services in every small town. There has to be a system. We have worked at that. There are several hospitals with the different kinds of specialties that help serve communities. We have had more and more critical access facilities which make it easier for small communities to work.

I visited Dubois, WY, this week, a new clinic to a small town. I also met with a group of physicians and hospital operators in Cheyenne. We talked about some of these issues. Before it was over, these professionals, these providers, indicated they agree this system is broken and there needs to be some kind of change made in the future. I don't know the answer. I don't know that anyone yet knows the answer. I suggest to my fellow Members of the Senate and the House, we need to begin to take a look.

If I can start out by saying I am not one who favors a Federal socialized medicine program, we need to find some ways to do something with what we have now.

National health expenditures grew $1.6 trillion in 2002, a 9.3-percent increase over the previous year. The costs of health care generally have gone up 15 percent a year for several years.

It is hard to sustain 15-percent growth, particularly when, increasingly, health care for families is a relatively large portion of expenditures.

Health care as a share of GDP in 2002 was 14.9 percent, up from 14.1 percent in 2001. So we are seeing substantial increases. And over the years those increases have continued.

So one has to ask, if the costs are going up 15 percent a year, how long can you sustain that? What do we need to do? Folks are seeing double-digit premium increases each year, including Federal employees. So it is quite obvious to me that we cannot continue to grow rates at that level.

I indicated I had talked to some folks who certainly agree we need to deal with that. We face more challenges in the health care system than just reforming the public programs or addressing the nearly 42 million people—15 percent—who do not have health insurance.

There are some things, of course, we need to consider. We need to improve the underlying health care infrastructure. Its rising costs affect all of us. I think we have to take some of the responsibility for fixing that system.

We have a health care system today where, for instance, hospital charges do not reflect the actual costs because of public and private insurance reimbursements. I recently met with a hospital CEO in my hometown. At that hospital they had some very interesting topics they talked about. Their gross charges, for example, were $202 million; $80 million was written off; $120.7 million reflects actual costs; $1.4 million was income from insurance, and they had $3.3 million in other income. This is not a large profit margin.

What does that mean? No. 1, Medicare does not pay to the level of actual costs. Now, you may say, well, we need to keep the cost of Medicare down. That is true. On the other hand, if their payment is not equal to the cost, then someone else has to bear the cost; Medicaid even more so.

Medicaid pays even a smaller percentage of the actual cost than does Medicare. This is a combination, of course, of State and Federal programs. So we find that situation.

Charity, for those who are uninsured, for those who come in and are not able to pay, we still take them, of course. Trauma care, sometimes, is reimbursed by the county or the State. But if someone has an accident and arrives at the hospital, they are given care, of course, whether they have the ability to pay, whether they have insurance. And guess who pays the principal cost of that. Those who have insurance.

People who are insured represent about 35 percent of the people in a hospital, but they pay 98 percent of the cost. So what we are doing basically is taking the costs that are there, and those who have commercial insurance are paying a very large percentage of that cost. Therefore, we are shifting costs from the broad user base to a relatively small group who buy insurance, which causes the private insurance to be higher.

So there are some weaknesses there. Certainly, we have to do something about it. Health providers must shift this cost to private insurance or they do not make it up.

Emergency room costs, of course, are extremely expensive. They are used a great deal, particularly with Medicaid where there is no first-dollar payment by anyone. When anything goes wrong for someone who is under Medicaid, they can go to the emergency room because it does not cost anything.

Of course, we pay the highest prices for prescription drugs and shoulder the research and development costs for

much of the rest of the world. I think most of us are working on that issue. I think we are going to have a hearing next week in the Finance Committee to see if there is any relationship in terms of the trade aspect of it—with Canada, for example, where you can send goods from this country that cost a certain amount, and the Government up there says they will cost less. Is that part of a trade problem? I think it is something we ought to talk about.

Also, of course, one of the things we have tried to fix—and I hope we continue to try to do something about it—is putting a limit on noneconomic damages for liability in health care. We have tried to pass that. We tried to pass it in the Wyoming Legislature. I think, hopefully, they will continue to do that.

But what it has done in our State—and I think in a number of other States—is it certainly has raised the costs because the cost for malpractice insurance for practioners has gone up a great deal. It has also caused some practitioners, particularly OB/GYNs, to not serve any longer. Again, in a State such as ours, where there may be just one provider in a community, if that person does not provide services, then there is no one there and people have to go miles and miles to find care.

So it has a great impact. Not only is it the impact of increased costs to the provider, which he or she passes on to his or her patients, but it also has caused practices to be quite different and to be overly general about care. A number of years ago, if you hurt your arm, you would go to a general practitioner, he would fix it, put a cast on it, and you would go home. Now you would go in and: Oh, my gosh, you hurt your arm? You better see an arm specialist. We need to take some tests. We need to have an MRI and a few other things—all of which make care more expensive than it used to be. Some of that cost is simply for protection against malpractice lawsuits. So that is one of the things we can do.

We are seeing more and more small businesses being unable and unwilling to help provide health care for their employees. So there are all kinds of different problems that have arisen.

I think people, also, are probably less responsible for their own health. This idea that we should take care of ourselves a little better to avoid sickness—everyone agrees with that idea, but not everyone participates in that. So, again, we have some things that could be changed.

I met a gentleman who is promoting a new program, running a new program called Be-well. It is a program for employers who create health contracts with their employees under the proposition that the employer says to the employee: I am willing and able to cover your health care expense, your insurance expense. However, you must agree to do some things for your own health. You need to agree to exercise. You need to agree to do some things. You need to agree to this Be-Well program.

Most everyone agrees with that idea, but often there is not any real incentive to do that. This program provides an incentive to people to be more responsible for themselves.

So we face some real challenges. Physicians and providers are retiring earlier because of some of these pressures. Hospital vacancy rates for registered nurses, radiology technicians, and pharmacists have reached more than 10 percent. There are a number of hospitals that face rather severe shortages. We are also facing dental shortages. Again, in low population States, we are seeing the dental providers becoming an older group. Many are soon to retire. Frankly, there are not enough people standing in line waiting to replace them. We are working on trying to get a multistate dental training arrangement and also urging some assistance for underserved areas in this area as well.

So what I am interested in seeing is if we can start a little dialog on the broader issues that affect health care and health care costs and the ability to have access to health care for people in this country.

I will continue to work on this issue. We have been very involved in our office on rural health care. We are very pleased with some of the things that were done in the bill that we passed last year for Medicare.

I was very pleased that we passed that bill. To be sure, it is not finalized, but it is a first step in 30-some years to begin making changes. So we have had changes taking place with people but not a lot of changes in terms of how we provide health care.

Last year we had a forum on rural health care which is a little unique, but some of the problems are the same. We began to discuss those problems and to look to the future. That is what we have to ask, what is health care going to look like 5 or 10 years from now, if we can make that sort of projection, and then begin to look at what we can do to get where we want it to be rather than where we think it will be if we do nothing.

There are some ideas out there. I don't suggest they are all the best, but some are being talked about—tax credits to have a medical setaside for payments that you could keep tax free and then use it. In many cases you could use it for the first dollar cost, and then all you have to buy is a higher level insurance, which is much cheaper, catastrophic insurance, rather than the first low dollar, which is much more expensive. We are going to be working on a better medical savings program.

Association health plans have been talked about. The idea of insurance is to get enough people into the package so you can level out the cost between those who are less healthy and those who are more healthy. But if you do not have large numbers, that doesn't happen. There is some objection to that in terms of the States. I am not necessarily supporting all these ideas. But, for example, if you were a service station operator, you could be part of a national service station operators insurance program.

Some have talked about the idea that everyone, even if they had to be helped, should have insurance. We require insurance on your car. We don't require it, but somebody else has to pay for it. So that is something we should talk about.

Better education efforts for consumers to make healthier choices, certainly that is something we ought to take seriously.

As I mentioned, medical malpractice reform is clearly something we ought to do. We, obviously, have been blocked in the Senate from doing that.

There are a lot of issues we need to look at, and they deal with where we are going to be in a few years and where we are now. But we will be worse off in a few years unless we begin to deal with some of those issues.

I appreciate the time and look forward to continuing to have the debate.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I say to my good friend from Wyoming, before he leaves the floor, I share his frustration over our failure to act on any kind of medical malpractice reform. We have tried a broad approach. We have tried a narrow approach. We will be back again to try another narrow approach. We can't even seem to get cloture on the motion to proceed. That is how dug in the Senate seems to be against any effort to lower those liability insurance premiums for doctors. The Senator from Wyoming brings up a very important issue. I thank him.

RICHARD CLARKE

Mr. MCCONNELL. Mr. President, I come to the Chamber this morning to talk about Richard Clarke's testimony yesterday.

We all now know who Richard Clarke is. He has sort of burst on the national scene with his effort to defeat President Bush. Richard Clarke was the man in charge of counterterrorism under the previous administration for 8 years. During those 8 years, we had three terrorist attacks against America: In 1993, the first attack against the World Trade Center in New York; against the U.S. Embassies in Africa in 1998; and against the USS *Cole* in 2000.

The most aggressive action, apparently, Mr. Clarke was able to convince his superiors to take during those years was to launch a few cruise missiles at a single terrorist camp in Afghanistan and take out a pharmaceutical factory in Sudan—not a really robust response to multiple terrorist acts against American interests both in the United States and overseas.

Now Mr. Clarke has the gall to come forward and suggest that President